

**MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL**

SUBJECT: Sclerosing Injection of Varicose Veins APPLIES TO: MHP <input checked="" type="checkbox"/> MLTCP <input checked="" type="checkbox"/> MSSP <input checked="" type="checkbox"/> HEALTHSELECT <input checked="" type="checkbox"/>	Protocol #: PA P211.02 Protocol Pages: 2 Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Initial Effective Date: June 1999 Latest Review Date: May 2002
MIHS HEALTH PLANS APPROVALS: Director, Medical Management: _____ Date: _____ Medical Director: _____ Date: _____	

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Sclerosing Injection of Varicose Veins.

PROTOCOL:

- A. Sclerosing Injection of Varicose Veins
CPT: 36470-36471

 - B. The prior-authorization specialist **with prior authorization nurse review** may approve for the following diagnoses:
 - 1. 451.11 – Phlebitis and thrombophlebitis, femoral vein;
 - 2. 451.19 – Phlebitis and thrombophlebitis of deep vessels of the lower extremities, other;
 - 3. 451.2 – Phlebitis and thrombophlebitis of lower extremities, unspecified;
 - 4. 454.0 – Varicose veins of lower extremities with ulcer;
 - 5. 454.1 – Varicose veins of the lower extremities with inflammation **or**
 - 6. 454.2 - Varicose veins of the lower extremities with inflammation and ulcer.

 - C. If **any** of the following are present:
 - 1. Pain at the involved site,
 - 2. Thrombosis or history of thrombosis at the involved site,
 - 3. Phlebitis or history of phlebitis at the involved site **or**
 - 4. Other signs or symptoms of a significantly diseased vessel(s).
- Note: Procedure is covered in conjunction with surgical stripping and ligation.
- D. Specifically **excluded** from coverage are the following:
 - 1. Vessels that are asymptomatic;
 - 2. Spider veins;
 - 3. Telangiectasia;

4. If authorization request or claim is for procedures 36469 or 36469 **and**
 5. For Hereditary Hemorrhagic Telangiectasia or unspecified capillary disease, ICD-9 Codes: 448.0 and 448.9.
- E. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.
- F. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.
- G. If requirements are not met, Medical Director review is required.

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.